SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

LSA Staff:

Al Gossard, Fiscal Analyst for the Commission
Casey Kline, Attorney for the Commission

Authority: ***IC 2-5-26***

MEETING MINUTES[1]

Meeting Date:	**October 22, 2002**
Meeting Time:	**10:00 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 233**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**3**

Members Present: **Rep. William Crawford, Chairperson; Rep. Charlie Brown; Rep. Susan Crosby; Rep. Mary Kay Budak; Rep. Gary Dillon; Rep. David Frizzell; Sen. Patricia Miller; Sen. Robert Meeks; Sen. Vi Simpson; Sen. Samuel Smith.**

Members Absent: **Sen. Steve Johnson; Sen. Rose Antich.**

Rep. William Crawford called the third meeting of the Select Joint Commission on Medicaid Oversight to order at about 10:10 a.m. Rep. Crawford reminded members that this would be the final meeting of the interim, and there was no requirement that the Commission produce a final report. Rep. Crawford also indicated that the agenda would be taken out of order by first considering any legislative proposals members might have.

Consideration of Legislative Proposals

PD 3624 was presented to the Commission by Sen. Patricia Miller. This proposal would require that the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program be the payor of last resort. (See Exhibit 1.)

Sen. Miller stated that the reason for the bill is that there are reports that some individuals on the CHOICE program, a 100% state-funded program, would also be eligible for Medicaid waivers, which would be cost-shared with the federal government.

---

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

In response to a question as to who makes the determination of eligibility for these programs, Ms. Melissa Durr, representing the Area Agencies on Aging (AAAs), indicated that the AAAs perform that function, of which there are 16 located throughout the state. Ms. Durr also stated that the use of CHOICE funds as the payor of last resort was already required by state law.

[Note: The requirement that CHOICE is the payor of last resort is not currently in Indiana statute. The witness was testifying to the fact that the provision exists in administrative rules promulgated by FSSA under 460 IAC 1-4-7(d).]

She added that there are a small number of Medicaid-eligible individuals for whom CHOICE funds are used to help them meet their spenddown requirement for the Medicaid program, but the number of individuals and amount of money involved is very small.

Commission members indicated that some individuals prefer CHOICE over Medicaid. Ms. Durr stated that some providers have pulled out of Medicaid in favor of the CHOICE program because of Medicaid's relatively low rates. Ms. Melanie Bella, Assistant Secretary of the Office of Medicaid Policy and Planning (OMPP), responded that there was much variation and inconsistency in reimbursement rates for CHOICE providers throughout the state, while Medicaid has only one statewide rate. She stated that CHOICE contracts and reimbursement rates are negotiated separately by each of the 16 AAAs. The result is that the Medicaid program is at a relative disadvantage in some portions of the state.

In response to a question as to whether all of the slots on the Aged and Disabled (A & D) waiver are used, Ms. Bella stated that an additional 800 slots were released in FY 2002 and another 800 slots are to be released in FY 2003. Although some slots are used for the waiting list, most slots are alloted to the AAAs, and, if unused, the slots are reallocated to other AAAs. Releasing of additional waiver slots is contingent upon federal approval and state funding being available. Ms. Bella added that there are 1,000 slots intended for diversion and conversion priorities, which allows the state flexibility in filling those slots (i.e., individuals do not necessarily have to be taken off the waiting list in the order that they applied for the program, depending upon the individual's situation).

Mr. John Cardwell, IN Home Care Task Force, stated that there is still a large waiting list to get onto the A&D waiver, and that until the state decides to use all of the 8,000 waiver slots that are already approved, but unfunded, the people won't be able to use the waiver slots. Rep. Crawford added that he was troubled that the state is not taking full advantage of the opportunity to leverage additional federal funds through the waiver program.

No action was taken by the Commission on the legislative proposal.

Long Term Care Issues

Ms. Melissa Durr, Area Agencies on Aging (AAAs) -

Ms. Melissa Durr, representing the AAAs, presented a report and a set of recommendations to address the problems of Indiana's long term care system. The report and recommendations were developed by an ad hoc workgroup. (See Exhibit 2.) The workgroup includes Sen. Simpson, Sen. Lawson, and representatives of ATTAIN, ARC of Indiana, Indiana Homes and Services for the Aging, OMPP, and the Division of Disability, Aging, and Rehabilitative Services.

Ms. Durr reported the workgroup's recommendations as the following: (1) Eliminate the fiscal barriers that exist between Medicaid and the Medicaid waiver and allow individuals who qualify for either program to receive the services they need; (2) Remove existing barriers to medical assistance that create an "institutional bias"; (3) Establish a "continuum of care" by building

community options that would reduce the inappropriate institutionalization of individuals; (4) Create a Caregiver Support Program to make assistance available to informal caregivers and to make sure that quality care is given; and (5) Make assistance or incentives available to assist nursing homes in the conversion to affordable housing or assisted living facilities, possibly in the form of tax credits.

State Department of Health Inspection Report -

Mr. Zach Cattell, Legislative Liaison for the State Department of Health (SDH), introduced Ms. Liz Carroll, Assistant Commissioner for Health Regulatory Services for the SDH. Ms. Carroll presented a 24-page report on SDH's health facility inspection program pursuant to the reporting requirements of SEA 225 (2001). (See Exhibit 3.)

Responding to a question as to whether the surveying process is the same in all states, Ms. Carroll replied that all states are required to conform to federal regulations. It would be possible that states interpret some provisions differently, however, the Center for Medicare and Medicaid Services (CMS) attempts to create consistency among the states.

Mr. Steve Albrecht, Indiana Health Care Association -

Mr. Steve Albrecht provided testimony as a follow-up on the previous meeting of the Commission. He provided a document showing the reimbursement rate reduction for a sample of eight nursing facilities as a result of recent rules changes made by OMPP. (See Exhibit 4.) Rate reductions for the eight facilities varied from $2.15 to $15.30 per patient per day, effective July 1, 2002.

Mr. Albrecht reported that average nursing facility reimbursement was $104.92 (prior to the July 1 rule changes), which is $4.37 per hour for 24-hour care. And he quoted a national study which found that Indiana nursing homes lose about $8 per day per Medicaid patient (prior to the July 1 rule changes).

Mr. Albrecht suggested that providers will take two courses of action in response to the recent rule changes: (1) many providers will try to absorb losses as best they can (the SDH inspection process insures quality of care); or (2) more facilities will file for bankruptcy. In addition, reimbursement reductions are being implemented in the Medicare program at the same time, causing additional financial problems for the industry.

In response to a question as to the number and size of rate changes caused by the new rules, Melanie Bella, OMPP, stated that she can provide that information for each facility. She added that the rule changes are anticipated to save the state about $50 M annually.

Mr. Albrecht added that there is a ripple effect in the industry in that some primary care providers are no longer providing care in nursing homes because of the Medicare and Medicaid changes.

Mr. John Cardwell, Indiana Home Care Task Force -

Mr. John Cardwell provided Commission members with a pamphlet entitled *"Home Care for Hoosiers: The Need for Care and the Opportunities for Taxpayers"*. (See Exhibit 5.) He added that the pamphlet was the result of a research project as a collaboration of ten organizations. He stated that the aggregate public investment in long term care is dramatically skewed toward institutional care. This is, in part, because states are required by the Medicaid program to insure that resources are available for the entitled services. He added that nearly 25% of all nursing home beds in Indiana are unoccupied, at the same time that a very large waiting list exists for

home-based services. Mr. Cardwell recommended that it be put into statute that eligible individuals are entitled to home- and community-based services.

Mr. Cardwell stated that one survey estimates that 5,000 individuals in nursing homes could be served in the community.

Ms. Evonne Brandenburg, Beverly Health Care -

Ms. Brandenburg stated that she, as operator of a nursing facility, and Mr. Cardwell are not talking about the same people. She added that the individuals being admitted into her nursing facility tend to be emergency situations and in need of nursing home care, and she is, in fact, working to keep people in their homes.

In response to a question regarding problems that Oregon has had with their long term care system, Mr. Cardwell stated that Oregon is scrutinized very closely because of their large investment in home- and community-based care. They changed their system in 1980 and moved too many people into adult foster care.

Mr. Albrecht stated that he doesn't oppose CHOICE funding; it is all part of the entire system.

Sen. Simpson stated that one of the problems is that we tend to have silos of thought, rather than thinking in terms of providing an entire spectrum of care.

Rep. Frizzell suggested that the General Assembly should consider the feasibility of incentives or subsidies toward the purchase of long term care insurance policies.

Overview of the Disproportionate Share Hospital (DSH) Program -

Ms. Melanie Bella, OMPP, provided a document summarizing the Medicaid DSH program in Indiana. (See Exhibit 6.) The DSH program is for the purpose of providing additional funds to hospitals that serve a disproportionate number of low income patients with special needs. Each hospital's eligibility is based on utilization and revenue data reported in audited cost reports. DSH payments are subject to limits including the following: (1) an aggregate state limit of about $202 M in federal funds; (2) a hospital-specific limit for each provider; and (3) a state limit on DSH expenditures for Institutions of Mental Disease, about $81 M in federal funds in 2002 and expected to decrease to approximately $58 M in 2003. Currently, the Indiana program is at the aggregate state cap.

Total DSH payments for SFY 2000 were $311 M and were distributed to the following: state mental health institutions ($112.4 M), private psychiatric facilities ($2.0 M), municipal hospitals ($29.6 M), community mental health centers ($6.0 M), and acute care hospitals ($161.3 M).

The Indiana Medicaid program provides the state share of DSH payments to private psychiatric facilities and the first $26 M of acute care hospital DSH payments. For all other DSH payments, the state share is provided by the public hospitals through the use of intergovernmental transfers.

Mr. Tim Kennedy, Indiana Hospital and Health Association -

Mr. Tim Kennedy explained that the state share of DSH funding for community mental health centers (CMHCs) comes from certified property tax dollars, and some of the CMHCs technically qualify as a hospital because they have an in-patient component.

In response to a question as to whether any states use broad-based taxes rather than

intergovernmental transfers for the state share, Mr. Kennedy stated that Kentucky did, but Kentucky also uses the money for other purposes besides DSH.

Mr. Kennedy provided members with a document that lists the ten current DSH hospitals in Indiana and a brief statement on the purpose behind the DSH program. (See Exhibit 7.) He added that Indiana has been conservative in its participation in the DSH program, and Indiana hasn't taken advantage of program loopholes to the extent that other states have.

Mr. Kennedy added that much of the state share of DSH funding comes from non-state sources. He suggested that the state might wish to consider a counter-intuitive strategy that could benefit both the state and the hospitals: expanding Medicaid eligibility and splitting the federal reimbursement of approximately 62% of total DSH payments.

EDS Update -

Ms. Mary Simpson, EDS, provided an update on Medicaid claims processing. (See Exhibit 8.) The exhibit includes the following information on the state Medicaid program: quarterly and annual statistics on dollars paid and allowed; claims paid, denied, or adjusted; the number of eligible and receiving recipients; and the number of providers enrolled and participating.

Commission members requested additional information regarding the decrease in the number of providers, as well as additional information on dental providers and recipients by county.

Update on the Collins Case -

Ms. Melanie Bella, OMPP, provided the Commission an update on the court decision in the *Collins vs. Hamilton* lawsuit. (See Exhibit 9.) Ms. Bella reported that the court found that Indiana's Medicaid program violates federal Medicaid law by refusing to cover long-term residential treatment for Medicaid patients under the age of 21 for whom such mental health treatment has been found to be medically necessary. According to Ms. Bella, the court ordered Indiana Medicaid to provide Medicaid-eligible children under 21 with psychiatric residential treatment facility services when found necessary by Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening examinations. These are payments for which counties currently have responsibility.

Ms. Bella reported that, to bring the state into compliance with this court order, OMPP must develop coverage and reimbursement policy, including provider enrollment requirements, utilization controls, medical necessity criteria, and the methodology for calculating Medicaid's reimbursement rate for the service. Ms. Bella also stated that legislation may be required in order to keep the counties involved if the state takes over some or all of the funding responsibility. OMPP is appealing the court decision.

Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative -

Ms. Carol Cutter, National Association of Health Underwriters, briefed the Commission on the use of HIFA waivers in providing health care benefits to uninsured children. (See Exhibit 10.) Ms. Cutter explained that, under a HIFA waiver, the state could use its existing Children's Health Insurance Program (CHIP) block grant funds to finance the waiver using the private, employer-based health insurance market. Ms. Cutter suggested that the focus of the program should be on children from families with incomes of 150% to 200% of the federal poverty level. She estimated that there may be 120,000 to 122,000 additional children who could qualify for the CHIP with this waiver. Ms. Cutter stated that she would like to meet with FSSA to discuss the best direction in which to proceed.

Rep. Crawford thanked members of the Commission for their attendance and participation in the Commission's meetings during the interim. There being no further business to conduct, the meeting was adjourned at approximately 1:00 p.m.